Withdrawal from Chemical Dependencies:

a resource manual

1985

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A Resource Manual

Prepared by:

P. Gilchrist
Administrator
Maple Cottage Detox Centre
Alcohol and Drug Programs

E. Birkenthal
Administrator
Pender Detox Centre
Alcohol and Drug Programs

M. Marett
Staff Supervisor
Pender Detox Centre
Alcohol and Drug Programs

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Introduction

This is written as a resource for people caring for chemically dependent persons going through withdrawal. It is meant to help identify problems that might arise and basic care requirements. It is also meant to provoke thought and creativity in assessing and managing people. Because the process may happen at home, in a hospital, in a non-hospital therapeutic setting, etc., persons have been referred to both as patients and clients.

Because this manual was prepared for a wide variety of people and agencies, procedures, processes and policies specific to the Ministry of Health Alcohol and Drug Programs' Detox services are not included. Anyone interested in such details should contact the detox administrators or staff supervisors.

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CHAPTER 1

GENERAL GOALS DURING WITHDRAWAL

- Detoxify body from effects of alcohol and/or other drugs
- Establish physical stability.
- Assist in stabilizing crisis situations.
- Increase self-esteem
- Identify needs and goals.
- Increase motivation toward continuing rehabilitation
- Prepare for and help with appropriate referral(s) for further treatment.
- Assist in decisions about future, encourage independent behavior.

  Increase feelings of personal responsibility for situation and future.
- Minimize the sick role, (up and dressed as soon as possible, keeping bed and unit tidy, spending majority of time with others in a lounge area, medications not taken directly to persons.)

CHAPTER 2

INTOXICATIONS - SIGNS AND SYMPTOMS

A. **Alcohol** - A central nervous system depressant.
   - Ethyl - beer, wine, liquor, cough syrup, vanilla, etc.
   - Methyl - anti-freeze, paint thinner, solvents, etc.
   - Isopropyl - shaving lotions, rubbing alcohol, disinfectants, window cleaners, etc.
     * Poor coordination, staggering gait, slurred speech, impaired reflexes, blurred vision, dilated pupils, unusual behavior (euphoria, anger, aggressiveness, loudness, passiveness, loss of inhibitions, etc.), impaired memory, excessive mood swings.
     * Visual hallucinations, runny nose and/or eyes, headache - suspect methyl alcohol or other drug ingestion.
     * May increase to stupor and coma with increased respiratory depression and decreased motor function.
     * Effects are more pronounced as amount ingested increases.

B. **Narcotics** - heroin, Methadone , Demerol , morphine, Darvon , Talwin , codeine, 292's , Percodan , Dilaudid .
   * Drowsiness or insomnia, dizziness, poor coordination, dry mouth, pinpoint pupils, euphoria, itchy face and nose, constipation.
   * Slurred speech - suspect poly-drug use.
   * May progress to respiratory depression, coma with lowered B.P. and increased pulse and cold, clammy skin.
   * Use indications - empty cough syrup bottles, dirty syringes, blackened spoons, empty pill containers, track marks, etc.

C. **Sedatives/Hypnotics/Minor Tranquilizers**
   - Nembutal , Seconal , Tuinal , Amytal , Luminal , Mandrax , Sominex chloral hydrate, Doriden , methaqualon (Quaalude), etc.
   - Librium , Valium , Serax , Dalmane , Halcion , Ativan , Gravol , Antihistamines, etc.
     * Poor muscle coordination, staggering gait, drowsiness, dilated pupils, euphoria , lethargy, "floating" feeling, impaired judgment.

- May progress to slurred speech, confusion, paradoxical excitement/rage, stupor, coma, respiratory failure
- Excessive use may cause headaches, rashes, stomach disturbances, urinary frequency or retention.

D. **Solvents**

- Glues, plastic cements, model cements, household cement, aerosols, gasoline, paint and lacquer thinners, nail polish removers, lighter and cleaning fluids, etc.
  - Staggering gait, poor coordination, dizziness, slurred speech, exhilaration.
  - May progress to disorientation and drowsiness.
  - May further progress to blurred vision, perceptual disorientation, runny nose and/or eyes, headache, nausea, abdominal cramps, enlarged pupils, vomiting, confusion, hallucinations.
  - May further progress to poor reflexes, coma, convulsions.
  - Can cause brain, liver, kidney and bone-marrow damage.
  - Death can occur by suffocation.
  - Use indications - sweet and sickly odour on breath and clothing, runny nose and/or eyes, possession of tubes of glue or cement or bottles of solvents, paper or plastic bags or handkerchiefs or pieces of cloth with glue in them, empty nail polish bottles in secluded places, etc.

E. **Stimulants**

- Cocaine, Benzedrine , Dexedrine , Methedrine , Ritalin , Preludin , Tenuate , etc. - "snow", "coke", "speed", "crystal", "meth", "uppers"
  - Euphoria, mood elevation, impaired judgment, increased motor activity, feeling of increased alertness and energy, talkativeness, wakefulness.
  - Anorexia, restlessness, dizziness, delirium, agitation, anxiety, insomnia, confusion, irritability, paranoia, aggressiveness/ hallucinations/delusions.
  - May lead to depression, nausea/vomiting, fatigue, headache, dilated pupils, dry mouth, diarrhea/abdominal cramps, exaggerated reflexes, stereotyped and repetitious behavior (touching and picking of face/extremities).

* Can progress to tremor, increased or decreased blood pressure, slower pulse, excessive sweating, pallor or flushing, chills, increasing fever, heart palpitations, chest pain, cardiac arrhythmias, convulsions, coma
* Death may occur from circulatory collapse (amphetamines) or respiratory failure (cocaine).
* Indications of use include needle "tracks", red/sore/runny nose (cocaine).

F. **Psychedelics**

- L.S.D., M.D.A., mescalin, psilocybin, PCP ("hog", "angel dust", "peace pill",) etc.
  * Initial feelings of anxiety and apprehension are not uncommon and may last throughout.
  * Dilated pupils, increased B.P. and pulse and respiration rate, increased body temperature, chills, muscular weakness, excessive mood swings, fear/paranoia, altered sensation and perception (auditory and visual distortions, color intensification, time distortions, etc.), non-logical thought sequences, disorientation, feeling of being outside one's body.
  * Some psychedelics may be administered by needle so "track" marks may indicate use.

G. **Major Tranquilizers and Anti-Depressants**

- Chlorpromazine, Largactil, Stellazine, Mellaril, Haldol, Nozinan, etc.
- Amitriptylline, Imipramine, Lithium, etc.
  * For signs and symptoms of use review basic information in a pharmaceutical publication with a pharmacist or prescribing physician.
  * These are not traditionally thought of as drugs that are abused or that people become dependent on, however, their use in general medical practice is increasing. They are often taken with other drugs that are more frequently abused like the benzodiazepines.

CHAPTER 3

WITHDRAWAL - SIGNS AND SYMPTOMS

A. **Alcohol**

- Range from fairly mild to very severe.
- Severity not entirely predictable from amount and/or duration of consumption.
- Onset - between a few hours to a few days after cessation of drinking.
  - precipitating factors include trauma, infection, metabolic disorders.
- May last 2 - 7 or more days.
  - * Reddened, puffy complexion and eyes.
  - * Tremors - of hands, tongue, mouth.
  - * Increased pulse rate.
  - * Sweating.
  - * Agitation.
  - * Nausea, vomiting, general loss of appetite.
  - * Insomnia.
  - * Dry mouth.
  - * Diarrhea.
  - * Anxiety/depression.
  - * Mental sluggishness.
  - * Confusion, disorientation.
  - * Hallucinations/delusions (often paranoid).
  - * Toxic psychoses.
  - * Seizures - see Appendix.
  - * Delirium tremens.
    - Most severe form of withdrawal.
    - Usual onset 2 - 3 days after cessation of drinking.
    - See Appendix for a more complete discussion.
  - * Craving for alcohol.

B. **Narcotics**

- Range from mild to severe - depends on amount and quantity used for what period of time.
- May begin immediately or not until 72 hours after last dose - depends on physical and emotional health, etc.
  - Tremors - lower limbs and hands.
  - Headaches.
  - Teary eyes, runny nose, sweating.
  - Loss of appetite, nausea, vomiting, diarrhea.
  - Unsteady gait.
  - Anxiety/depression/agitation/irritability/restlessness.
  - Insomnia.
  - Aches and pains - lower extremities.
  - Abdominal and leg cramps.
  - Muscle spasms.
  - Craving for narcotics.
  - Dry mouth.
  - Fever.
  - Itchy, irritated skin.
  - Gooseflesh.
  - Hot and cold flushes.
  - Yawning.

C. **Sedatives and Hypnotics**

- Varies from mild to severe - depends on drug used, strength, quantity and length of dependency.
- May last 10 days or more (especially in quantities of 20-30 or more pills daily).
  - Unsteady gait, dilated pupils.
  - Tremors - hands and limbs.
  - Headache.
  - Slurred speech - may be under the influence of a drug or may be a possible toxic reaction.

* Anxiety/depression/irritability.
* Craving for the drug
* Insomnia.
* Nausea.
* Fever.
* Sweating.
* Temporary psychosis.
* Seizures - may occur due to sudden cessation of use in especially heavy users - can progress immediately to "status epilepticus" - one grand mal seizure after another with no periods of consciousness between seizures.

D. **Minor Tranquilizers**

- Withdrawal can be delayed up to 2 weeks or longer - usually begins in 5-7 days from last dose.
- Withdrawal may be quite prolonged - weeks.
  * Anxiety/agitation.
  * Restlessness.
  * Insomnia.
  * Depression.
  * Possible seizures - dose and time related (more likely with higher doses used over longer periods of time).
  * Hyperacusia
  * Emotional liability
  * Diminished attention span
- Withdrawal can be frustrating to everyone involved because of the length of time it takes. The patient appears reasonably physically well but has great difficulty coping emotionally. The course of withdrawal is often up and down with the patient feeling better some days and then worse again. The patient is often afraid he/she is

"crazy" and requires frequent support and reassurance.

- The longer a patient has abused these medications the more likely psychotic symptomatology is to appear during withdrawal. This is very frightening to the patient.

E. **Solvents**

* Anxiety.
* Depression.

F. **Stimulants**

* Craving.
* Fatigue.
* Prlonged sleep.
* Increased appetite.
* Depression.
* Rebound REM sleep with cocaine withdrawal.

G. **Psychedelics**

* Anxiety/agitation - usually related to recurring "flashbacks" (a psychotic-like reaction).

H. **Major Tranquilizers**

* Withdrawal symptomatology is difficult to predict. Consult a good reference source - e.g., CPS, Goodman & Gilman text, knowledgeable psychiatrist, etc.
* It may be useful to gradually withdraw these medications one at a time to provide adequate assessment and prevent major psychiatric disturbances.
* The prescribing physician should be consulted where possible before initiating the withdrawal.

CHAPTER 4

COMPLICATIONS OF CHEMICAL DEPENDENCY - GENERAL

A. **Physical**

* Inattention to good health requirements (i.e., hygiene is usually poorer, sleep is usually disrupted, nutrition is often unbalanced and inadequate).
  Plus continuous and large amounts of drugs that the body must work overtime to metabolize.
  Plus effects of drugs on muscle responsiveness, judgment, etc.
  Plus drug toxicity.
  Plus increased exposure to potentially harmful situations and people (falls, overdoses, violence, etc.).
  Result in increased susceptibility to trauma and disease.
* All body systems can be affected - may begin fairly benignly and progress to life-threatening situations over a period of time.

Examples:

* diabetes - onset or worsening.
* hypoglycemia.
* pancreatitis, liver cirrhosis.
* ulcers, diarrhea, other digestive system difficulties.
* head injuries from falls, blows, etc.
* seizures.
* broken bones, torn and strained muscles and ligaments, infections.
* cancers
* chronic respiratory problems - emphysema, pneumonia, bronchitis.
* heart and other circulatory problems.
* nervous system deterioration and disorders - numbness, tingling, memory problems.
* malnutrition, vitamin deficiencies.

B. **Emotional/Psychological**

- Increasing loss of self-esteem, poor self-image, increasing dependency on others - especially as providers of an immediate "magical" cure imposed from outside.
- Increasing feelings of guilt, anger, depression, anxiety, confusion, despair, isolation, etc.
- Drug use may have developed as a way of dealing with emotional pain resulting from problems - abuse often leads to increased numbers and severity of problems - results in further increase in drug consumption to handle the feelings the problems bring out - a vicious, escalating problem spiral.

C. **Psychiatric**

- Toxic effects of drug(s) may produce temporary toxic psychosis (irrational behaviour; partial or total disorientation to reality - time, place, person, hallucinations, delusions, paranoia, suicide attempts, etc.).
- Acute episodes of underlying psychiatric problems may be triggered (depression, psychosis, etc.)
- Current psychiatric difficulties (acute or chronic) may be worsened.

D. **Family**

- Instability increases - anger, arguments, blaming, demands increase, isolation, possible separation/divorce, threats, inconsistent messages and follow-through, etc.
- Using drugs as a way of handling problems is modelled for other family members - other members may begin to abuse same or other substances.
- Loss of family support, assistance.
- May be child/spouse abuse - custody problems, apprehension of children, assault charges, incest, etc.

E. **Legal**

- Arrests, charges, convictions may occur and increase - criminal and non-criminal - e.g., driving while impaired, careless driving, prostitution, assault, theft, breaking and entering, possession, trafficking, murder, etc.

* Difficulties often arise while under the influence of a substance or while trying to get money for living and drug expenses or while acting out negative feelings.
* Subsequent incarceration, heavy fines, parole, probation, legal fees, etc.

F. **Job**

* There may be no loss of ability to perform one's job initially until dependency is quite advanced.
* Threat or actual loss of job.
* Diminished abilities to do the job adequately, loss of esteem of peers/supervisors/employer.
* Jobs become harder to get and hold - poorer health, chronic health problems, poor references, loss of skills, inability to keep up with newest information/procedures, etc.

G. **Financial**

* There may be little loss of funds initially if income is very high or abuse is very regular and doesn't increase.
* May be an increasing inability to regularly earn enough or to have enough left from pay cheques after purchasing desired chemical substances to meet regular and extraordinary (legal fees, fines, etc.) expenses - may lead to loss of home, a need to move more frequently to lower rent areas, a limit on quantity and quality of food/clothing available, inability to pay debts, a need for further debt, possible bankruptcy, requirement for welfare, etc.

H. **Social**

* Friends/community may label abuser as "deviant", immoral, weak, harmful, etc.
  - Can result in friends pulling away, rejection by the community, a smaller circle of acquaintances who also abuse substances.
  - Leisure choices may become limited by financial constraints, physical problems, incapacitation from substance use, etc.

I. **Behavioral**

* May be any form(s) of negative, unexpected, unacceptable behavior.
* May be associated with physical ill health, psychological/psychiatric problems, habit, etc.

* Behavior is usually designed to get what the person needs and/or wants with as little personal responsibility taken as possible - may be an inability to accept and deal with failure to get what is desired, so being able to blame someone else is more desirable.
* Designed to get immediate satisfaction - the person often has problems waiting for, or working slowly and step by step toward anything.
* Passiveness, withdrawal, insisting on sleeping all day, inability or refusal to interact with others.
* Inappropriate boisterousness, joviality, jokes.
* Obscene language and/or gestures.
* Manipulation of others - starting and spreading gossip, accusing, playing staff off against each other, lying.
* Demands, constant seeking of attention, whining, yelling.
* Preoccupation with physical health.
* Pacing, general agitation, hand wringing, shrill voice.
* Threat of and/or actual aggression or violence - may be associated with hallucinations/delusions/paranoia.
* Increased childishness - curling up in fetal position, talking with voice inflections of a younger person, etc. - often seen in people with illnessess - a regression to earlier behaviors.
* Denial of any problems/addictions, struggle to excuse behavior and justify it - possible rejection of persons trying to help/confront - possible anger/violence if pushed too much, too soon.
* Generally, the person feels unwell - physically and mentally - and struggles to feel better. Also, a residential setting often provides person with a feeling of safety in terms of finally being able to express angers, anxieties, fears, etc., or person may be trying to punish him/herself and reaffirm own feelings of non-worth by making others reject him/her.

Problems in one or more or all of the above areas may be experienced at any time. Multi-crises often negatively affect one's willingness and readiness to enter into ongoing treatment/rehabilitation programs. With initial stabilization in some of these life areas the person often becomes able to think and do something concrete about treatment and long-term goal planning.

CHAPTER 5

ASSESSMENT FOR WITHDRAWAL - GENERAL

Evaluation/assessment of client's physical state, emotional/behavioral state psychological/psychiatric state/social/personal/financial/legal/occupational situation, etc., is done in order to define problems and needs and in order to determine appropriate interventions. Assessment findings change from moment to moment and from situation to situation. The more stable a person is when assessed, the more reliable the findings may be over longer periods of time.

A. **Assessment Priorities**

* Assessment areas can never truly be separated from each other; however, certain areas may need more attention than others at any given time.
* The physical state is always given top priority as it is vital that physical needs be met in order to maintain life.
  - Healthier, more physically stable people respond better to assessment and exhibit less severe emotional, social, etc., dysfunction than someone who is physically very ill.
  - Assessment accuracy of all other areas is dramatically increased when the patient is able to function at as physically healthy a level as possible.
* Behavior is the second assessment priority as it may reflect or influence problems in the physical state and/or other areas.
  - To enhance or maintain a patient's physical well-being, safety, etc. and/or to protect others it may be necessary to assess behavior first. E.g., an aggressive, threatening person with a head wound may present a danger to himself and others. It may be impossible to assess the head wound until the behavior has been changed. In such situations behavior assessment in order to manage and change it is the first priority. Only when the behavior has been dealt with can the physical assessment continue. At times it may be necessary to

assess both areas at once.

* All other life areas may be assessed as opportunities arise or as need indicates.

B. Assessment During Different Stages of Withrawal

Admission Assessment

* Immediate needs must be determined to establish what needs to be done to ensure the person's safety and comfort, how best to orient the person to the unit, the type of area to admit to, whether a bath is required, whether vital signs need to be monitored, etc. The initial assessment may help determine whether the person is suitable to your unit and can be admitted.
* Also establishes baseline information to compare with future data in a meaningful way.

Physical:

- Wounds, bleeding, etc.
- Level of consciousness.
- What has been ingested over last 24 hours and in what amount - time and dose of last ingestion - this gives an idea of when withdrawal may start, whether overdose possibilities exist, etc.
- Any current or chronic problems especially with heart, lungs, ulcers, diabetes, liver, pancreas, seizures, infectious diseases.
- Weight - state of nutrition - last meal.
- Color and condition of skin and hair.
- Odors.
- General hygiene.

Behavior:

- Appropriateness.
- Level of anxiety and agitation.
- Passive, aggressive, withdrawn, demanding, etc.
- What person is doing and saying and how (body movements: hand wringing, crying, pacing, etc.; tone of voice, loudness of voice, affect, etc.)
- General way of interacting with staff and others.

Emotional/psychological/psychiatric

- Anxiety level: low to panicky.
- Signs of depression.
- Suicidal actions or expressions.
- Signs of hallucinations, delusions, paranoia, etc.
- Confusion level, degree of awareness of where person is, time of day, etc.

Social, Familial, etc.

- Take note of what information is given.
- Get an idea of any family needs of an immediate nature (such as care for young children).
- Note names of referring agent(s), people accompanying the patient/client, names of other professionals involved, etc., for future assistance and involvement if necessary.

Ongoing assessment

After admission until discharge - primarily concerned with needs during withdrawal but provides much necessary information for discharge/referral planning.

Physical:

- watch for changes indicating decreasing or increasing problems.

Behavioral:

- manipulative, dependent, aggressive, passive, withdrawn, agitated, etc.
- Need for direction vs. independent action.
- Appropriateness.
- Type and quality of interactions and relationships with staff, other patients/clients, visitors, e.g., "loner", gregarious, seeks contact, avoids contact, etc.
- Expressed interests.
- Programs participated in - enthusiasm level.
- Responsiveness to others' suggestions and ideas.
- Reaction to efforts to discuss the nature of the dependency, plans, etc., e.g., denial, seeks discussion, downplays seriousness, etc.

- Amount of responsibility taken by person as opposed to efforts to blame problems on others.
- Level of activity - many will have excess nervous energy 12-24 hours into withdrawal which may result in pacing, etc.

Emotional/psychological/psychiatric:

- Watch for changes indicative of a decrease or increase in problem areas.
- Affect and appropriateness.
- Level of anxiety.
- Depression, agitation, hallucinations, delusions, paranoia, etc.

Social/familial/legal, etc.:

- Continue to note all information available for inclusion into final assessment.
- Note crisis areas and arrange for consultation and/or necessary assistance; e.g., spouse won't accept person back into home, children being taken into care, threatened or actual loss of job.

Discharge/Referral Assessment:

- Begins on admission, takes account of all physical, behavioral, psychiatric, social, etc., information available and includes specific information, as follows:
  - In-depth assessment of the drug use behavior - length of problem, triggering events, primary place of use, number of family members and friends that also use and/or abuse the drug(s), degree of internal control, previous treatment tried and results.
  - Stress situations present in all areas.
  - Presence of supportive individuals.
  - Person's attitude to the problem and assessment of what would be an achievable goal(s).
  - Presence or absence of behaviors required to reach stated goal(s)
  - Continuing physical, emotional, social, etc., problems that make goal attainment difficult.
  - Overall realism of person's goals(s).
  - Planned actions to reach toward goal(s).

- The overall assessment should lead to suggestions for ongoing treatment programs appropriate to the individual's needs and wants.

C. **Assessment Tools.**

- An open, flexible, questioning mind.
- Acceptance of individuals as unique from each other.
- A belief that people can change their behavior.
- An ability and willingness to listen.
- An ability and willingness to accept different perspectives.
- An awareness of own values, attitudes and reactions and an acceptance that different ones are also acceptable for others.
- A willingness to allow people to control their own lives and goals and to try the treatment programs they feel are right for them.
- General objectivity.
- Non-judgmental approach.
- A knowledge of "normal" and "abnormal" physical states, behavior, emotional/psychological states, etc.
- A knowledge of degree of functioning required in different areas in order to succeed at different goals.
- Special tests
  - Temperature, blood pressure, pulse rate, blood work, X-rays, etc.
  - Psychological tests - depression scales, confusion level tests, reality orientation, etc. - most of these kinds of tests should be done after detoxification to increase validity of results.
- Other professionals with higher levels of skills and more experience in certain areas such as medicine, social work, psychology, law, etc.
- Experience.
- Books, courses, etc.

CHAPTER 6

INTERVENTION/MANAGEMENT - GENERAL CONSIDERATIONS

* Occurs when assessment processes indicate a need for it.
* The purpose of intervention is to change behavior (of body systems or behavior, etc.) from a less safe and more negative situation to one that is safer and more positive;

  e.g., aspirin administration to reduce a high fever,
  antibiotic administration to reduce infection, warm bath to reduce anxiety, support and encouragement to follow through on a commitment to stop drinking or taking pills.
* Priority must be given to maintaining life and increasing physical health at all times;

  e.g., usually it is not appropriate to sit on someone or hold them down to put a bandage on a wound when they are also very anxious and agitated. However, if the wound is bleeding profusely you will have to physically restrain the person as quickly as possible in order to be able to treat the person to keep them from losing too much blood, etc. You can deal more specifically with the anxiety later.
* Should happen as soon as possible after recognizing a problem exists (and accurate, continuing assessment is necessary for this to happen) to prevent the problem from attaining such serious proportions that more drastic intervention measures are required;

  e.g., a hostile, agitated person should be reasurred, directed into activities that allow for release of tensions, etc., as soon as the increasing hostility is recognized. This can prevent the problem of possible attack and drastic staff actions such as intramuscular medication, police assistance, physical restraint, etc.
* For specific interventions - physical, social, behavioral, etc., see specific problems section.

CHAPTER 7

PROBLEMS DURING WITHDRAWAL AND HOW TO MANAGE

A. **Physical**

- **Tremulousness**
  - Severe tremors - low doses of mild tranquilizers for one or two days; "prn" whenever possible.
  - Adequate carbohydrates and proteins in diet to control hypoglycemia.
  - Rest.
  - Limit caffeine intake.
- **Irritability, Startling**
  - Keep environment as calm and quiet as possible, avoid sudden and loud noises.
  - Avoid approaching people quietly from behind - make sure person knows you are coming.
  - May require mild tranquilizers in low doses for one to two days; "prn" whenever possible.
- **Seizures**
  - Persons with a history of withdrawal seizures may require daily medication for a few days.
  - Persons with epilepsy require continued medications. If barbiturates are one of the anti-epileptic medications this should be reviewed, as most patients can be successfully managed on a non-barbiturate prescription. The taking of barbiturates will increase a person's chance of recidivism.
  - Avoid startling very tremulous persons.
  - Avoid very disturbing emotional upsets.
  - Limit TV-watching, very bright lights and continuous loud noise levels.
  - See Appendix.
- **Muscle Spasms/Cramps**
  - Warm baths, light exercise, possible calcium supplementation, relaxation exercises.

- **Delirium Tremens**
  - * This condition is a medical emergency and has a significant mortality rate. The best treatment is prevention:
    - . Ensure adequate rest; watch for increase in body temperature, confusion, hallucinations.
    - . Re-establish adequate diet, vitamins and minerals as soon as possible.
  - * Tranquilizing will be necessary.
  - * See Appendix.
- **Insomnia**
  - * Medicate only when absolutely necessary - try other measures first.
  - * Limit time spent asleep during the day.
  - * Encourage relaxation exercises.
  - * Warm milk drinks before bed.
  - * Have person take a warm bath.
  - * Calcium supplementation may help.
  - * No distressing visits/discussions, etc. before bed.
- **Nausea/Vomiting**
  - * Small, frequent bland liquids.
  - * Try liquid jello followed by eggnog in small amounts.
  - * Minimize noise, light and activity levels around person - minimize odors when possible (don't wear perfume).
  - * Good room ventilation, person lying flat on back, cool cloth on forehead, slow/deep breaths, concentrate on something more pleasant, general relaxation exercises.
  - * Gravol orally or by injection or suppository if above interventions are not working.
- **Stomach Discomfort/Indigestion**
  - * Small/frequent/bland meals
  - * Antacid in small amounts
  - * Relaxation exercises
- **Diarrhea**
  - * Stop intake of milk for alcohol abusers.
  - * Dry toast, plain strong tea, crackers.
  - * Possible need for medication until controlled.

Summary

Generally, besides physical problems resulting primarily from chemical abuse, the abusing person is more susceptible to all other disease processes. It is not good enough to ignore abnormal signs and symptoms based on a feeling or judgment that it results only from normal withdrawal or exists simply as an attention-getting device. When abnormal signs and symptoms are noticed they must be carefully noted and assessed further. Certain things warrant immediate medical attention, others require further medical assessment and care, chronic problems require ongoing care.

It is not **NORMAL**

* To have to gasp/struggle for breath.
* To have an elevated body temperature.
* To lose consciousness.
* To be confused and disoriented.
* To not breathe.
* For a heart to stop beating.
* To become harder or impossible to rouse.
* To experience continual numbness/tingling of body parts.
* To experience severe pain.
* To not be able to move - "paralysis", "fractures".
* To breathe very slowly or rapidly or very deeply or shallowly.
* For a pulse to be very slow or very fast or irregular or fluttery.
* To vomit forceably - "projectile".
* To pass fresh or old blood in urine, stool or vomitus.
* To have burns, severe bruising, stab wounds, open cuts, etc.
* To be very itchy, to have continuous discharge from any body openings (especially if tinged with blood, pus, etc.).
* To be jaundiced (yellow) or cyanotic (blue).

Make sure you know what a normal body temperature and pulse rate is. Establish baselines for individuals - abnormalities and changes toward abnormality need to be assessed by a doctor. Profuse bleeding, sudden loss of consciousness, chest pain, breathing problems, cardiac arrest, rapid deterioration of pulse/color or change in level of consciousness are emergencies and deserve

your undivided attention and the immediate attention of medically-trained help (doctors, paramedics, etc.). **Get it!**

For a complete explanation of specific problems and diseases (how to recognize, how to intervene) and as a ready reference at all times make available to yourself: a good medical dictionary, a current Compendium of Pharmaceuticals and Specialties (CPS), a super medical surgical nursing textbook and a first-aid text. See References. Experience develops over time with practice.

B. **Nutritional**

* Generally, alcohol and drug abuse are commonly associated with malnutrition - upset stomachs, ulcers, decreased appetite, etc., can result in an inadequate amount of food eaten, constant intoxication can result in forgetting to eat, personal food preferences, cravings can lead to inadequate quality of food eaten regardless of quantity, a drug's toxic influence on the body may result in the body cells being less able to use the nutrients available to them.

* **Deficiency diseases common in alcohol abusers:**
  - Protein - produces symptoms of fatty liver, hypoalbuminemia, hypocholesterolemia, edema, normocytic anemia.
  - Vitamin - Thiamine.
    . Symptoms involve muscle and/or nerve tissue irritability and are directly related to the degree of deficiency.
      * Mild - problems involve lower limbs only.
      * Moderate - alcoholic beri-beri, also affects heart muscle metabolism and may lead to congestive heart failure.
      * Severe - Wernicke's syndrome, plus Korsakoff's psychosis, if confusion persists.
  - Nicotinic Acid
    * Alcoholic pellagra.
  - Pyridoxine
    * Vague syndrome of nervousness, irritability, insomnia, mild ataxia and skin lesions, also suggested as cause of withdrawal seizures.
  - Folic Acid

    - * A major cause of macrocytic anemia in alcoholics.
  - Mineral - most often involves sodium, chlorine, potassium, magnesium and zinc - symptoms: general dehydration and mild to severe acidosis.
    - * Hypomagnesemia is suggested to be a cause of development of delirium tremens.
- * Zinc deficiency is suggested to be a component of hypogonadism.
- * Potassium depletion can cause confusion, agitation, heartbeat irregularities and seizures.
- * Most common signs of deficiencies - weight loss or gain, swollen/inflamed tongue, anemia.
- * The sooner good nutrition can be initiated with persons in withdrawal, the sooner the person will recover and the less severe the withdrawal symptoms need to be.
- * For persons in acute withdrawal - disoriented, confused, agitated, lacking appetite:
  - A diet high in carbohydrates, easily digestible, providing a minimum of 2,000 calories a day, moderately high in protein, presented in small amounts quite frequently (at least 6 times a day) - mostly liquid or soft.
- * For persons with acute tremulousness - anxiety, insomnia, tremors, mental sluggishness, lacking appetite:
  - A diet high in carbohydrates and protein, a minimum of 2,000 calories daily, catering to as many food preferences as possible, presented in small/frequent servings.
- * For persons in post-withdrawal:
  - A diet high in protein, carbohydrates and calories, frequent meals, containing high amounts of vitamins and minerals.
- * Other important considerations
  - Have a nutrition textbook available for reference - see References.
  - Consider a complete food supplement for people with severe stomach upset and lack of appetite. ENSURE is excellent - especially for persons with diarrhea related to lactase problems.

* People with diabetes need a diabetic diet and careful observation and teaching.
* Ulcer problems require small meals of foods that are well tolerated and careful observation and teaching.
* Whole grains provide excellent food value - especially important minerals and vitamins.
* Offer snacks, etc., with high potassium and protein value.
* Vitamin supplements may be necessary - especially thiamine - 100 mg. daily is usually sufficient.
* Coffee should be de-caffeinated and limited in amount. Caffeine is a stimulant, contributes to tremulousness and sleeplessness.
* Other caffeine-containing foods should be limited - tea, coca-cola, chocolate, etc.

C. **Emotional/Psychological/Psychiatric**

- **Anxiety**

* Darting eye movements, feeling of internal shakiness, "butterflies" in stomach, increased tremulousness, insomnia, inability to sit still, unwillingness/inability to continue discussing certain topics, anger when pushed to talk about certain things, wringing of hands, pacing, rapid breathing, etc.
* If you notice increasing anxiety soon enough and quickly do something about it, medication may be unnecessary.
* Be alert. Ask yourself why the person may be anxious - think about what has been happening around the person, what you have been trying to get the person to talk about, etc.
* Help the person identify the fact that anxiety is present/increasing, etc.
* Suggest ways of decreasing anxiety and help person follow through.
  - A warm bath, with bubbles, with a shampoo and blow-dry.
  - Focusing on something more pleasant.
  - Going through a relaxation exercise program.
  - Focusing on and developing a plan to deal with the cause of the anxiety.

- **Depression**

* Loss of energy, decreasing interest in maintaining personal hygiene, tendency to wear dark-colored clothing, insomnia, desire to sleep or stay in bed as much as possible, increasing difficulty in responding to people, sad expression, low voice, monosyllabic answers to questions, frequent sighing, may be agitated and pacing.
* Do not force to interact with others but encourage by limiting time allowed in bed during the day, by insisting meals be taken with others, by insisting some short periods throughout the day are spent sitting with others, etc.
* Attempt to get person to acknowledge and talk about the depressed feelings.
* Assess for possible suicidal thought/ intention.
* Excessively cheerful approaches are likely to further depress people, be calm, firm, caring.
* Arrange for professional psychiatric assessment if depression continues or deepens or suicide is a possibility.
* Give medications ordered.

- **Suicidal**

* A person may have attempted suicide before, perhaps very recently. Ask if person ever thinks of suicide.
* Arrange for professional psychiatric assessment and care as soon as possible.
* Watch very closely - check total environment person has access to and make it as safe as possible, it may be necessary to get a staff person to accompany the person **everywhere** if suicidal intent/desire is present.
* Watch cords on drapes, laundry bags; no belts or tie, no breakable items; no utensils; no private baths/showers; no electrical appliances near water, etc.
* Medicate as ordered.
* Do not deny to person that you are concerned - it will be obvious - do not overdo it but be honest.

- **Hallucinations**

* Person sees/hears/feels/tastes what is not real. For many drug abusers insect/animal hallucinations are common.
* Persons may have periods of lucidity interspersed with periods of confusion and disorientation.
* There is a sense that the person is "not with you" but off in a world of his/her own - may not answer direct questions - may look fearful when approached - may be talking to self.
* There may be paranoia present - person believes people/things are out to harm him/her - may lead to attack to protect self against imagined foes.
* Arrange for immediate professional psychiatric assistance.
* Watch person carefully and warily - keep calm, do not let your guard down - don't get backed into corners.
* Don't make sudden moves; don't come up behind a person without making your presence known well in advance; don't startle the person.
* Keep lights at intermediate levels; noise minimal; numbers of surrounding people as small as possible.
* Do not threaten at all - if help is necessary go and get it. Don't try to convince the person it is in his/her best interests.
* Don't get involved in the substance of the hallucination(s) - don't argue who's right or who's wrong - state your own perception and deny seeing/hearing, etc., what other sees/hears - reassure that it will not last and that you will not let harm come to the person.
* Many people are aware they are "seeing things" and are further upset at this added evidence of personal loss of control - embarrassment and anger are also common; do not laugh, it is not really funny.
* Be aware of ways to protect self and others - use them if necessary.

- **Anger**

* A common reaction to feelings of loss of control over one's life; to not having expectations met.
* May show up in tightened jaws/mouth/lips, fierce looks, clenched and shaking fists, rise in loudness of voice, yelling, screaming, threats, verbal assault, physical attack (on objects and/or people), depression, suicide attempts (anger turned back on one's self).

* The sooner you recognize the beginnings of anger and do something to help the person control it the less chance there is that anyone will get hurt and the greater chance there is that the person will learn a less destructive way of handling frustrations and disappointments.
* People often respond to anger with anger and the situation further deteriorates - be aware that this is the least positive of responses and is often exactly what the angry person wants - it's a good excuse to completely "fly off the handle" and abdicate personal responsibility.
* Trying to help the angry person talk about why the anger has developed. Really listening and trying to understand can be very helpful. Acknowledge the feelings a person expresses, be realistic and do not try to smooth out difficulties by making promises you are not prepared or able to keep. Don't threaten verbally or physically.
* Do not shut yourself into a room with angry, hostile patients/clients; do not back yourself into a corner; tell other staff where you will be and alert them to the problem; don't intrude on the person's physical space, give them room.

- **Threats of physical aggression/violence.** Don't laugh them off; don't threaten in return; remain calm and controlled; state limits of acceptable behavior; suggest the person tell you what is wrong so you can help defuse the problem - angry people often fear the loss of control that they threaten and may be persuaded at the initial signs of increasing anger to channel it more appropriately into vigorous physical activity (running, jumping, playing ping-pong/tennis, etc., punching a punching bag, etc.).
    - in conjunction with hallucinations, paranoid delusions, etc., persons can still be rational and capable of much control - arrange for assistance as soon as the problem arises
    - do not try to reason but reassure person and state what is acceptable behaviour.
- **Violence/attack** - often begins with threatening physical posture (person stands up, leans forward, picks up a weapon, grabs for you, etc.), facial grimacing, etc.; may be accompanied by yelling, screaming, etc. Call for help immediately.

- When deciding whether to try to restrain physically or not, remember that extremely upset/out-of-control people often have great strength and that they may not be rational at that moment; try to gauge how close to rational the person is (can you gain his/her attention or is he/she apparently oblivious to the people around).
  - Do not try to restrain unless you are certain you can succeed; you or someone else may be injured in the process. Take enough other trained people with you and agree on the restraint method(s) to be used; tranquilizing medication may be necessary.
  - If only property is being attacked, try to reason with person if possible. Stay out of line of attack and keep everyone else away until a team is ready to move in and restrain if necessary.
  - if you or someone else is the object - retreat to a safe location when possible. Try to contain the attack in one area (lock a door, barricade a hallway, etc.) Try reasoning, approach with a team when ready.
  - If someone else is being attacked and cannot escape, do not try to restrain without help. Try to divert attention to yourself and move away from person being attacked.
  - If you are being attacked and injured, protect yourself as much as possible - yell/scream to alert others to your need, use aggressive physical maneuvers when able. Refer to Prevention and Management of Disturbed Behaviour techniques. (See references).
- When the attack has been handled, if the person is still with your unit, there will be a need to discuss what happened, what led up to the situation, what else you could have done, how the person feels now (often guilty, ashamed, remorseful, afraid) and what can be done to prevent recurrences.

D. **Behavioral**

- Expect the whole range from fairly reasonable, motivated and independent to very dependent, manipulative and attention-seeking.
- All behavior is both a response to other behaviors and a stimulus designed to get a certain behavior in response; understanding our own behavioral responses and reactions is helpful in understanding others'

behavior and its effects as well as in managing our own behavior to modify that of others in directions of our choice.

- Illness and problems in any life area tend to lead people to identify themselves as sick and therefore deserving of attention from others who will "make them better" - illness and disruptions often also result in regression to more childish behaviors developed and used in earlier life stages (temper tantrums, aggression, whining, constant complaining, unwillingness to do as much as one is capable of in caring for oneself, desire to spend one's time in bed, decreased tolerance for pain and discomfort, decreased attention-span and frustration tolerance, etc.). People like to stay in pyjamas, lie in bed, desire pills to mask all withdrawal discomfort, etc. Get them up and dressed as soon as possible, encourage socializing in common living areas, involve them in their own planning and in the care of the unit; generally encourage adult, self-responsible behaviors.
- Dependent, childlike behaviors often trigger parenting responses ("talking-over", judgmental, moralistic, disciplinary, etc.). In return one sees increased childishness, dependency. It is important to remain on an adult level to encourage more adult responses from patients/clients.
- Direction from staff is often sought; encourage discussion, offer alternatives for consideration. Do not direct (tell people what they should do) as this discourages them from making their own decisions and from taking responsibility for their behavior.
- Even very intoxicated persons are usually aware of what they are doing; simple directions and an insistence on acceptable behavior are useful staff responses.
- During withdrawal and stabilization, a fair amount of structure and planned activity is necessary. Also required are clear-cut, consistent standards of behavior in several areas (visiting hours, meal times, areas where smoking is permitted, etc.).
- Game-playing and other manipulative behavior is designed to get attention, redirect the focus and energies of staff to less threatening areas of action/discussion, get more medication than is required, divert attention from unacceptable behaviour (e.g., taking illicit drugs), etc. It

often involves turning staff against each other, decreasing staff's trust for each other, making staff feel inadequate and harsh, etc. Manipulation is very effective when staff are not communicating well and are busy; staff must remain firm, be consistent, stay calm, be objective, work as a team and communicate and check things out with each other as often as necessary.

- Recognize as quickly as possible when behavior is becoming unacceptable and immediate intervention is necessary to prevent the situation from becoming worse.
- Never threaten a consequence unless able and prepared to follow through immediately.
- Really listening can prevent further manipulative behaviors before the real problem is identified and can be worked on.
- Being busy is never an acceptable excuse for ignoring patients/clients for long periods of time; make time every twenty minutes or so to check briefly on your patients/clients and reassure them; a lot of complaints and attention-seeking will disappear.

E. <u>Social, Legal, Occupational, etc.</u>

- Often a referral/consultation with employer, Human Resources worker, social worker, lawyer, Legal Aid, etc., will be helpful/necessary; the person should make as many of the contacts as possible (encourages personal responsibility).
- Reassurance that solutions are possible, that someone is working to help the person resolve the problems, and that the problems are real can be helpful in decreasing accompanying anxiety, attention-seeking, etc.

CHAPTER 8

REHABILITATION

* The general question of motivation is extremely complex; what is motivating for person A may not be for person B.
* The threat or actual loss of physical health, spouse, job, children, etc., may induce many people to seek help; for others nothing may appear to make any difference and it may seem as if the person is actively trying to destroy himself/herself.
* The first attempt to resolve the problem(s) may result in success or many attempts may be necessary.
* Success may be long-term or short-term with few or no future efforts necessary to regain stability and resolve the chemical dependency.
* Generally, people in crisis are ripe for suggestions from helping agencies/persons, and commitments made during crisis resolution can lead to successful, long-term problem resolution.
* Depending on the problem severity and number of life areas involved, people will be better suited to some forms of treatment than to others, e.g.:
  (1) Short-term outpatient counselling may not be supportive enough for someone who has no job, has not worked for six years, has few friends and no family, etc., and requires intensive retraining in life skills.
  (2) Long-term residential support with non-specific counselling may be inappropriate for the working person with an intact family and a relatively recent chemical abuse problem.
* Adequate assessment is very important in helping the patient/client identify what form of ongoing assistance will be most useful -community professionals such as psychologists, social workers, alcohol and drug counsellors, etc., may be helpful in these efforts; keeping up-to-date information on services available in the community is also useful.

- Rehabilitation begins from the time a person steps through your door; a non-judgmental, warm, firm, consistent, realistic and adult approach that encourages personal responsibility and actively involves the person in problem definition and ongoing treatment planning is essential at every stage.
- The frequent need to repeat the withdrawal and other treatment processes for the same individual is very frustrating to care givers and can lead to anger, feelings of guilt, feelings of inadequacy, etc.

  BURNOUT - staff must appreciate their limitation and inability to control others and the process of recovery in order to master the frustration and maintain an ability to work effectively.

CHAPTER 9

STAFF CONSIDERATIONS

- Staff working with chemically dependent people need to be mature, stable individuals able to allow others to hold different values and attitudes and to lead alternate lifestyles from their own; need to be able to listen effectively.
- Staff should be trained in basic CPR and first aid techniques, need to have a basic understanding of psychology, sociology and pharmacology and need several years of general life experience.
- Staff should have a minimum of 1 year experience in a related area.
- Staff require good, consistent supervision and assistance in order to handle frustrations positively.
- Staff need to be trained in good communication techniques and need to function as a team at all times.
- Staff require ongoing practice and training in behavioral assessment and management - especially in regard to manipulation, aggression and dependence.
- Staff should have training in problem-solving processes.

APPENDIX

Specific Physical Problems Often Encountered During Withdrawal

- Signs and Symptoms (Assessment)
- Intervention/Management

1. **Seizures**

   * Indicate an uncontrolled discharge of electrical impulses between neurons in the brain.
   * Can be caused by head injuries, fever, hypoglycemia, infection, toxins (carbon monoxide, carbon tetrachloride, other chemicals, alcohol, etc.), phenothiazine administration to alcoholics in withdrawal, neglecting to take medication for epilepsy, intracranial haemorrhage, nervous system disease, infections, metabolic disease, etc.
   * Usually occur in first 48 hours of withdrawal except for barbiturate withdrawal when they usually occur after the third day.
   * Are usually grand mal in nature, sometimes progress to status epilepticus (one seizure after another without intervening consciousness).
   * Usually do not recur outside the withdrawal process.
   * Can be brought on by loud or sudden noises, flashing lights, some types of music, prolonged T.V. viewing (flickering images/exciting content), increased emotional stress, fatigue, etc.
   * May be preceded by increased irritability, depression, headache, dizziness, twitchiness, voracious appetite, sometimes an "aura", often a loud and involuntary cry.
   * Usually last 1/2 to 3-1/2 minutes; progress through tonic phase (total body rigidity, unconsciousness, no breathing) to clonic phase (irregular, jerky movements of body, noisy breathing, sometimes foaming of mouth and some signs of bleeding in mouth area, pupils dilated and unreactive) incontinence of urine is common, incontinence of feces is rare.
   * Consciousness returns - may be confused, dazed, wish to sleep several hours, may not remember seizure, may have headache and feel weak.

* Note hours into withdrawal, any medications given prior to seizure and at what time, time of seizure onset, whether onset observed, seizure duration, whether all or just a part of the body was involved, any incontinence/bleeding, any wounds sustained during seizure, size of pupils, how person regained consciousnesss.

* **Care**

To prevent:

- Monitor T.V. watching, encourage rest and good nutrition, control noise level, use anxiety-reducing measures generally, medication if appropriate.

During seizure:

- DO NOT FORCE JAWS OPEN TO PUT ANYTHING BETWEEN TEETH; turn person on side as soon as possible to aid breathing and drainage of secretions; move furniture out of way where possible; clear area of observers; cushion head with your knee, blanket, pillow, hand etc.; loosen restricting clothing (especially around neck); loosely contain flailing arms and legs to prevent injury - do not hold tightly or fractures could result; stay with person through seizure; when consciousness returns, reassure, reorient, encourage rest, keep person calm, take care not to startle the person or touch too much (if possible) -another seizure could be triggered; arrange for further medical attention and assessment.

2. **Delirium Tremens**

* Usually begins 2 - 4 days after alcohol intake stops.
* May begin after severe nightmares or a seizure, although this is rare.
* May be precipitated by a head injury, surgery, or an infection.
* May occur with brief periods of lucidity.
* Delirium tremens can be prevented by close observation for a progression of the abstinence syndrome or of withdrawal symptoms. Prevention measures require prompt and adequate intervention, usually in the form of sedation.
* Signs and Symptoms: increased pulse and blood pressure and temperature; profuse sweating; dry mouth; pupils dilated and sluggish; unsteady walk; increasing tremulousness; loss of appetite; severe insomnia; extreme irritability and agitation; very talkative;

uncontrollable fear or panic and increasing anxiety; increasing confusion and disorientation (to time, place, person); loss of memory for recent events; hallucinations (usually visual, tactile, auditory and involving "bugs"), and illusions (dogs on roller skates, people looking like monsters, etc.); persecutory delusions (paranoid).

* If not treated may progress through complete exhaustion to cardiac and/or respiratory arrest and circulatory collapse.
* **Care**
  - Arrange for complete examination (person may require hospitalization with sedation, monitoring of vital signs, etc.); follow doctor's orders for medication, fluid monitoring, etc.; early recognition may prevent emergency; supervise constantly when agitation/confusion severe and prevent person from injuring self or others; decrease environmental stimuli - lower noise level, minimum number of persons interacting with the patient/client, lights at intermediate levels, do as many things as necessary all at once; approach calmly, speak clearly and concisely in even tones - avoid low conversation with others which can increase paranoia, don't chatter, carry out procedures matter-of-factly and quickly but don't "rush" the person; use anxiety-reducing measures like warm drinks; don't agree with hallucinatory/delusional content - acknowledge person's perceptions, listen, reassure - do not try to convince the person of the reality; encourage rest and adequate amounts of fluids and a high-protein, high-carbohydrate diet.
  - When the "d.t.'s" subside, the person often is embarrassed and feels guilty - fears, delusions, etc., are often remembered very clearly and the person swears off continued drinking; an accepting, reassuring and supportive approach is very helpful and staff can use the experience to try to motivate the person into constructive action to prevent future episodes.

3. **Head Injuries**
   * Head injuries may result in serious and emergency problems.
   * Can cause headache, increased intracranial pressure, decreased strength/sensation, paralysis (may be one-sided), body temperature changes, vision/speech problems, coma, etc.

* Signs and Symptoms:
  - History of trauma, decreasing levels of consciousness, bruises/swelling/pain in head, pupil size/equality/reactivity changes, sudden onset or progressive development of paralysis/loss of strength/loss of sensation (may be one-sided), nausea/vomiting (projectile), changes in pulse/respiration/blood pressure/temperature, pink or red fluid leaking from ears/nose, confusion/disorientation/ irritability.
* Care:
  - Arrange for immediate medical attention, have someone stay with the person, reassure, calm person, keep environment as calm as possible, give nothing to eat or drink, restrict activity, keep person in a sitting position or raised to a 45 degree angle.
  - Everyone with a recent history (previous 3 days) of trauma to the head and who has not seen a doctor should be assessed by one as soon as possible.

4. **Decreased Levels of Consciousness**
   * Indicate depression of central nervous system.
   * Causes: head injuries, stroke, decrease/loss of oxygen to brain, drug overdose, increased fluid in brain area, toxins, diabetes, tumors, neurological dysfunction.
   * Fully conscious: alert, wakeful, relatively calm, oriented to time/place/person, can speak, moves body parts as asked, eyes open spontaneously, pupils react quickly, vital signs normal, co-ordinated muscle action.
   * Decreasing levels of consciousness Signs and Symptoms:
     Progressive loss of co-ordinated muscle action, more and more lethargic and restless, increasing confusion and disorientation, speech becomes full of inappropriate words and responses - then consists of incomprehensible sounds - then is absent, eyes open less spontaneously - must ask person to do so - then open only to painful stimuli - then remain closed, pupils

respond more sluggishly, it becomes increasingly difficult to rouse the person, responses to painful stimuli diminish - from flexion to pain (drawing of body part toward self) to extension to pain (extending body part away from self) to none, corneal and gag responses may also be lost and person deteriorates into a deep coma.

* **Care:** Arrange for medical assistance, stay with person, if unconscious, place person in 3/4 prone position, maintain an open airway.

5. **Drug Overdose**

* Signs and Symptoms: possible progressive deterioration in level of consciousness, others as per CPS for specific drug(s) suspected, person may say she/he has taken an overdose, empty pill bottles may be found on person/in belongings, etc.
* **Care:** arrange for medical assessment and care, stay with person, maintain an open airway.

6. **Hyperventilation**

* Signs and Symptoms: anxious; rapid/deep breathing; possible sudden loss of consciousness and cardiac arrythmias.
* **Care:** stay with person; have person breathe as you command - deeply and slowly, not rapidly and shallowly - count slowly for person, "breathe in 1,2,3", "breathe out 1,2,3", reassure, have person breathe into a paper bag until breathing returns to normal.

7. **Partial Respiratory Obstruction**

* May be caused by: asthma, bronchitis, emphysema, food or something else stuck in back of throat or "windpipe", etc.
* Signs and Symptoms: person can still make some sound and breathing is noisy - gasping, wheezing, gurgling; extremely anxious; may be clutching throat area; nostrils flared; may be some swelling in the throat area; skin becomes bluer - especially around lips and nails; person often bends over forward; may slowly or quickly progress to total obstruction.
* **Care:** arrange for immediate medical attention; medication as ordered for asthma, etc.; stay with person and try to calm down as much as possible; reassure person; loosen restrictive clothing; keep person sitting forward if some relief is felt in this position; clear area of unnecessary observers; perform appropriate first aid techniques.

8. **Total Respiratory Obstruction**

   * Signs and Symptoms: extreme anxiety; clutching of throat area; person cannot make any sound; breathing sounds absent; blueness of skin quickly apparent, loss of consciousness.
   * **Care:** get immediate medical assistance; perform appropriate first aid techniques; keep calm; reassure person.

9. **Respiratory Arrest**

   * Signs and Symptoms: no breathing, unconscious, blueness of skin.
   * **Care:** arrange for immediate medical assistance, check for obstruction, begin ventilation procedure, keep a close watch on pulse for continued presence.

10. **Other Acute and Chronic Respiratory Problems**

    * Pneumonia, pleurisy, T.B., bronchitis, other infections: watch for fever, cough/pus, weakness; refer to a physician for further assessment and attention.

11. **Cardiac Problems**

    * Keep a fairly close/unobtrusive watch on people with a history of heart problems.
    * Heartbeat irregularities are not rare in people going through withdrawal; a doctor should see the person having this type of difficulty.
    * Cardiac pain

      Signs and Symptoms: difficulty breathing, increasing anxiety/feeling of impending doom, skin and mucous membranes become dusky in color (tinged blue), irregular/fluttery/very fast or slow pulse, complaints of chest pain - may be substernal (around mid-chest), may increase with exercise/rise in temperature of surroundings/increased coldness of environment/rise in stress, may only last 5 minutes or so and subside with rest, may continue even with administration of medication such as nitro-glycerine, may radiate to neck/throat/jaw/down left arm to back, may be "crushing"/"cramping" in nature.

      Care: arrange for immediate medical assistance, start oxygen if trained in its administration, stay with person, reassure/try to calm person, loosen restrictive clothing, raise to a 45 degree angle.

* **Cardiac Arrest**

  Signs and Symptoms: person collapses/loses consciousness, no breathing, no pulse (check the carotid pulse in neck), color dusky, pupils fixed and dilated.

  Care: arrange for immediate medical assistance, begin external cardiopulmonary resuscitation and continue until told to stop by a physician or paramedic.

12. **Bleeding**

* May occur in sudden large amounts (hemorrhage) or in continuous, smaller amounts.
* May be external or internal, may be very visible.

  Signs and Symptoms: vomit containing bright red blood and/or dark coffee-ground looking material; urine tinged pink to red; feces tinged bright red or very black and hard; blood tinged fluid from ears/nose; external wounds from which blood is flowing or spurting; tenderness and pain in affected area; shock (may develop rapidly or more slowly) - pale/cold clammy skin, shortness of breath, nausea, dizziness, restlessness, blood pressure falls, pulse increases.

  Care: External - elevate part if possible, put pressure on part and/or pulse point closest to wound and between wound and heart, arrange for immediate medical assistance.

  Shock - arrange for immediate medical assessment and assistance, place person in a position where legs are slightly higher than rest of body, give nothing to eat or drink, calm and reassure person, watch very carefully after initial problem has been solved.

13. **Severe Pain**

* May indicate a number of physical problems; e.g., heart problems, perforated ulcers, gallstones, kidney stones, hemorrhage, appendicitis, neuritis, neuralgia, spinal injury, earache, fractures, pancreatitis, etc.
* Pain is individual and tolerance varies greatly between people and situations - there are cultural ties to pain, its tolerance and its expression.

Signs and Symptoms: verbal complaints; body positioning to protect painful area; holding the painful area; immediate retraction of area when touched or when person thinks it will be touched; general tenseness of entire area or entire body; decreased ability/willingness to move around; pale, clammy skin; facial grimacing; moaning/groaning, etc.; increased anxiety/irritability; inability to carry out directions well or answer questions fully; attention-span diminished.

Care: get medical assessment right away, stay with person, reassure, turn down harsh lights, decrease noise levels, keep numbers of people around person to an absolute minimum, help person maintain a focus on something more pleasant, encourage "panting" breathing (watch that you don't get hyperventilation), encourage relaxation as much as possible (low/soothing voice, etc.), give nothing to eat or drink, no hot water bottles without a doctor's order.

14. **Fractures**

Signs and Symptoms: a history of trauma, pain, swelling, reddening, warmth, possible bruising, unusual position or "out-of-place" appearance, reduced ability to move the part concerned, bone(s) may have broken through skin (bone(s) visible, bleeding).

Care: arrange for immediate medical attention, stay with with person, help person into a comfortable position, put a dressing (sterile, if possible) over any breaks in the skin, splint the joints on both sides of the injury to completely immobilize area, elevate part and apply ice, nothing to eat or drink, reassure person and encourage as much relaxation as possible.

15. **Back/Neck Injuries**

- May lead to spinal cord injuries.

Signs and Symptoms: tenderness at site of injury, swelling, bruising, person may be supporting head and be afraid/unwilling to let go, abnormal position of head, numbness/tingling of limbs possible, possible inability to move limbs.

Care: DO NOT MOVE, call for immediate medical attention, nothing to eat or drink, keep airway open (move MINIMALLY to accomplish if necessary), reassure person, keep person still - be very firm but do not unduly alarm person.

16. **Burns**

* May be superficial (skin red but no destruction) or show blisters or be full-thickness (skin waxy, yellow or charred, may be leaking fluid from burned area).
* Can be caused by: careless smoking when intoxicated or very tremulous during withdrawal, scalds from hot beverages or tub baths/showers, swallowing chemicals, friction (sliding along a floor or wall, etc.) etc.

Care: prevent further injury to superficial burns (cool with ice/water); have blisters assessed and care for as directed; full-thickness burns require immediate and intensive care; cover with a clean sheet, ensure an adequate airway, keep person as quiet as possible. **DO NOT APPLY ANY OINTMENTS/WATER/GREASES, etc., DO NOT TRY TO CUT AWAY CLOTHES OR PULL THEM OFF;** for burns that are healing watch carefully for signs of infection.

17. **Hyperglycemia**

* May be chronic (as in diabetes) or acute (a result of alcohol abuse, sudden pancreas problems, etc.).

Signs and Symptoms: confused; uncooperative; barely arousable or totally unresponsive; breathing is rapid, deep, forced and pauseless; skin is red, warm, dry; breath smells of nail polish/apples.

Care: arrange for immediate medical assessment, stay with person, reassure, maintain an open airway, watch closely, if the problem is chronic (diabetes) ensure person takes medication, put person on a diabetic diet, watch carefully during withdrawal.

18. **Hypoglycemia**

* Too little "sugar" available to body for "energy".
* May be a chronic problem or an acute situation caused by too much insulin or continued alcohol abuse, unusual over-exertion, etc.

Signs and Symptoms: general weakness/trembling, pale/cool skin, sweating, headache, faintness, numb or tingling tongue or lips, double vision, unsteady gait, confusion, increased pulse rate, slow/shallow breathing, unconsciousness.

Care: arrange for immediate medical assessment and care, stay with person, if conscious give person some very sweet juice, followed by a piece of cheese or something else high in protein content to prevent further hypoglycemia; if this is a chronic problem cut down on carbohydrate intake and increase protein intake and have person eat smaller meals more often (6 times a day).

19. **Liver Problems**

- Especially in alcohol and other drug abusing persons but also present in toxic substance ingestion situations and general liver disease.

  Signs and Symptoms: enlarged liver, loss of appetite, nausea, vomiting, epigastric pain, jaundice, white or light-colored stools, skin susceptible to bruising from minor trauma, weakness, weight loss, abdominal pain/tenderness, orange/brown urine, swelling of hands/feet, dry/flaky/itchy skin.

  Care: arrange for medical assessment, lots of rest, vitamin supplements as ordered, diet moderate to high in protein content and high in calories, small/frequent meals, meal supplements as ordered.

20. **Pancreatitis**

- Often associated with excessive intake of alcohol.

  Signs and Symptoms: severe abdominal pain which may radiate to the back, nausea/vomiting, possible jaundice, frequent/frothy/foul-smelling stools.

  Care: refer to medical attention; when acute problem has been resolved, have person avoid coffee, spicy foods, heavy meals (all gastric stimulants) - teach relaxation procedures to help person avoid build-ups of stress and emotional upsets.

21. **Gastro-Intestinal Problems**

a. **Mouth and throat problems** arise due to poor nutrition and hygiene.

- Cancer is quite common - usually a combination of alcohol and heavy smoking.

Signs and Symptoms: pain, chronic irritation, swellings, complaints of continuing sores/pain, difficulty swallowing.

Care: encourage good oral hygiene and no smoking, refer to medical assessment.

b. **Esophagus problems** include cancer, esophageal varices, (varicose veins - caused by advanced cirrhosis of liver), inflammation.

Signs and Symptoms: pain, blood in vomit (small to large amounts - can indicate irritation or a rupture of a varicose vein).

Care: bland, soft diet; minimize vomiting and dry heaves, refer for medical assessment.

c. **Stomach problems** include ulcers (which can rupture), nausea, vomiting, general irritation (heartburn, indigestion).

- Ulcer Signs and Symptoms: pain in stomach area under diaphragm, possible vomit containing fresh red or old dry, "coffee-ground" blood.

Care: soft, bland, diet; smaller and more frequent meals, refer to hospital if blood appears and give nothing to eat or drink.

- Nausea - Signs and Symptoms: person complains of wanting to "throw-up", sweating, pallor, frequent swallowing, increased salivation.

Care: lie down in darkened, cool, quiet area, fresh air if possible, medication such as Gravol; cool cloth on forehead; deep breathing; relaxation exercises; nothing to eat; sips of hot jello/water.

- Vomiting: may be usual and contain food, may be "dry heaves" or may consist of bile, may be projectile (expelled with great force) without warning.

Care: clean up person, rinse mouth, wipe face, encourage rest and relaxation, refer for medical attention if projectile in nature or containing blood.

* General Irritation

Signs and Symptoms: complaints of burning, feelings of fullness, gassiness, loss of appetite.

Care: small, frequent, soft, bland foods, antacid.

d. **Intestinal Problems:** include poor absorption of nutrients, inflammation, ulcers, diarrhea, constipation.

Signs and Symptoms: may include abdominal pain, tarry or clay-colored stools, blood in stools, etc.

Care: diarrhea often results from a temporary milk intolerance and will clear up quickly with no milk products in diet. If problem worsens or persists unreasonably refer for medical attention.

22. **Vitamin and Mineral Deficiencies:** many problems arise out of vitamin and mineral deficiencies.

Signs and Symptoms may include skin problems, vision losses, nervous irritability, weight losses, nervous system disorders, unsteady gait, mental confusion, etc.

Care: adequate diet, possible vitamin supplementation, adequate medical assessment.

a) **Acute Polyneuropathy** (disease of lots of nerves) - peripheral (fingers, toes, etc.) nerve degeneration results from lack of Thiamine and B12.

Signs and Symptoms: muscle wasting, especially in legs; deterioration of pain and touch sensations in feet; progresses to numbness/tingling/burning sensations; gait is unsteady as person can't feel floors properly; gait appears flat-footed with a widened stance.

Care: caution in baths (may not feel water is too hot) and with hot water bottles, warn of stairs/obstructions, explanation of the problem, vitamin supplementation.

b) **Wernicke Encephalopathy:** steady drinking for years, weight loss, poor nutrition, cirrhosis, anemia, loss of subcutaneous fat, global mental confusion, unsteady gait, involuntary rapid movement of eyeballs, double vision, polyneuropathy.

Korsakoff Syndrome: loss of memory of recent events, retains past memories (fills in gaps with fabrications).

Care: thiamine supplementation, no alcohol, constant orientation to present, short and simple directions and explanations.

23. **Infections and Infectious Diseases**

Signs and Symptoms: increased body temperature, general aches and pains, weakness, sweating, restlessness, etc.

Care: refer to medical attention, medications as ordered.

b) **Infections of Body Parts**

Signs and Symptoms: pain/redness/swelling/possible drainage in area, possible red streaks from area toward heart.

Care: refer for medical attention, medications, soaks, dressing changes as ordered.

c) **Lice (crabs)**

Signs and Symptoms: itchy head/armpits/groin/chest, etc., nits stuck to hairs/look like dirty freckles especially in areas other than head, itching bites, eggs in clothing seams.

Care: launder cloths in soap and Kwellada (separately from everyone else's clothes), avoid sharing towels (washcloths)/combs/bedding, mark and separate bedding for special laundering, avoid close body contact, wash hands well after contact, shampoo and bath using Kwellada/Cuprex, etc., comb hair with fine comb.

d) **Scabies (mites)**

Signs and Symptoms: progressive itching (worse at night), open sore areas especially in folds of skin between fingers/in arm pits/under breast/in groin.

Care: hot bath, thorough scrubbing of open areas, application of Benzyl Benzoate 25% or other medication as ordered, isolate and separate bedding and other linen for special laundering, good personal hygiene.

e. **Gonorrhea**

Women: vaginal discharge may be slight, possible fever/pain/cramps diarrhea/abnormal menstrual flow.

Men: 15-20% have no symptoms, rest may experience burning sensation when urinating, possible watery discharge which becomes heavier/thicker/creamy colored.

Care: regular checkups, medical assessment, medication as ordered.

f. **Syphilis**

A sore (chancre/ulcer) develops (usually in genital area), disappears, a rash develops in a month or two and disappears, disease becomes dormant, may reappear years away in large/open sores and can lead to arthritis, blindness, deafness, bone degeneration, insanity.

Care: any sore/swellings/discharges on and around sexual organs, any rashes should be checked out by a doctor immediately, medication as ordered.

g. **Genital Herpes**

Cold sores develop in the genital area and heal (usually 10 days to 2 weeks). May recur frequently, occasionally or never. Any sores should be checked out by a doctor; medication as ordered.

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